UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
TRENTON DIVISION

TARA KING, ***et al.,*** Plaintiffs, v. **CHRISTOPHER J. CHRISTIE*, et al.,*** Defendants.	Case No. 13-cv-5038

DECLARATION OF LAURA DAVIES, M.D. IN SUPPORT OF GARDEN STATE EQUALITY'S MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Laura Davies, M.D., hereby declare as follows:

1. I am over the age of 18 and make this declaration based on my personal knowledge. The statements in this declaration are true and correct and if called upon to testify to them, I would and could do so competently.

Qualifications

2. I received my undergraduate degree from Princeton University in 1992 and a Doctor of Medicine (M.D.) degree from the University of Southern California School of Medicine in 1997. I completed my residency in Child and Adolescent Psychiatry and General Adult Psychiatry at the University of California, San Francisco (UCSF) School of Medicine.

3. Since August of 2002, I have been in private practice as a child, adolescent and adult psychiatrist. I have served as a consultant psychiatrist for St. Luke's Hospital, California Pacific Medical Center, since 2007 and was formerly an Assistant Clinical Professor of Child and Adolescent Psychiatry at UCSF and a Child Psychiatrist in the Departments of Pediatrics and Psychiatry. In that capacity, I supervised psychiatric and pediatric residents, psychology pre-and post- doctoral interns, and medical students. I also directed the Behavioral Assessment Clinic, which addressed ADHD, PTSD, and other childhood psychiatric disorders.

4. I am Board-Certified by the American Board of Psychiatry and Neurology and am a Diplomate in the Subspecialty of Child and Adolescent Psychiatry. I am also a recipient of the Irving Phillips, MD Memorial Award for Excellence in Child & Adolescent Psychiatry. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

5. I have reviewed Plaintiffs' "Application for Temporary Restraining Order and/or Preliminary Injunction" as well as the accompanying declaration of Christopher Rosik.

6. I have been asked to provide this declaration as an expert in psychiatry in response to the statement by Christopher Rosik that there are "recent, high quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008; Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013, Wilson & Widom, 2009)." *See* Declaration of Christopher Rosik (Dkt. 3-

4) at ¶ 18. Rosik concludes this paragraph with a hypothesis that "same-sex attractions and behaviors" are "one of the possible consequences of sexual molestation and abuse." *Id.*

7. Subjecting minor victims of sexual abuse to sexual orientation change efforts ("SOCE") poses risks of serious harm to such victims for the reasons detailed below.

8. Across the mainstream scientific and medical communities, there is no longer any dispute about the following: Homosexuality is a normal variation of human sexuality; it is not a disorder. The American Psychiatric Association declassified homosexuality as a mental disorder as a result of significant research in 1973,[1] and the American Psychological Association followed suit in 1975.[2] Numerous studies have since confirmed that gay men and women can and do lead healthy, happy, and productive lives.[3]

9. There is no credible evidence that sexual abuse changes sexual orientation. The American Academy of Pediatrics has concluded that "there is no scientific evidence that abnormal parenting, sexual abuse, or other adverse life events influence sexual

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[1] *See generally* Am. Psychiatric Ass'n, *Position Statement: Homosexuality and Civil Rights* (1973), in 131 Am. J. Psychiatry 497 (1974).

[2] Am. Psychol. Ass'n, *Minutes of the Annual Meeting of the Council of Representatives*, 30 Am. Psychologist 620, 633 (1975).

[3] *E.g.* Roisman G. et al, *Adult romantic relationships as contexts of human development: A multimethod comparison of same-sex couples with opposite-sex dating, engaged, and married dyads*, 44(1) Developmental Psychology 91-101 (2008) (finding that "gay males and lesbians in our studies were generally not distinguishable from their committed heterosexual counterparts on measures of self- and partner reported relationship quality").

orientation."[4] The American Psychiatric Association similarly concluded that "no specific psychosocial or family dynamic cause for homosexuality has been identified, including histories of childhood sexual abuse."[5] The United States Department of Veterans Affairs has also concluded that "[s]exual assault does not cause someone to have a particular sexual orientation."[6]

10. Christopher Rosik cites five studies in support of his statement that "recent, high quality, and large-scale studies [] provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Bruckner, 2002; Francis, 2008; Frisch & Hviid, 2006; Roberts, Glymour, & Koenen, 2013, Wilson & Widom, 2009)." *See* Declaration of Christopher Rosik (Dkt. 3-4) at ¶ 18. Rosik concludes this paragraph with a hypothesis that "same-sex attractions and behaviors" are "one of the possible consequences of sexual molestation and abuse." *Id.*

11. In fact, four of the studies Rosik cites fail to support any connection at all between sexual abuse and sexuality and the last one has fatal methodological flaws. The purpose of the Frisch & Hviid (2006) study was to "examine childhood family correlates of heterosexual and homosexual *marriages*." *Arch Sex. Behav* (2006) 35:546. In other

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[4] Barbara L. Frankowski & the Comm. on Adolescence (American Academy of Pediatrics), *Clinical Report: Sexual Orientation and Adolescents*, 113 PEDIATRICS 1827, 1828 (2004).

[5] Am. Psychiatric Ass'n, *LGBT- Sexual Orientation*, http://www.psychiatry.org/lgbt-sexual-orientation (last visited Jan. 28, 2013).

[6] U.S. Dept. of Veterans Affairs, *Men and Sexual Trauma*, http://www.ptsd.va.gov/public/pages/men-sexual-trauma.asp (last visited Jan. 28, 2013).

words, the study sought to identify childhood factors that might impact a person's decision to marry; it did not analyze factors that might lead a person to be gay or lesbian. The authors also specifically warned against the misrepresentation of their study that Rosik asserts: "[O]ur findings should not be used incautiously to define childhood determinants of sexual orientation." *Id.*

12. Similarly, Wilson & Widom (2010) state repeatedly throughout their study that it does "not imply that sexual abuse 'causes' boys to grow up with a homosexual preference." *Arch Sex. Behav* (2010) 39:72; *see also id.* ("these findings do not suggest that same-sex sexual orientation is caused by child abuse"). There is also a serious methodological flaw in this study in that the researchers evaluated fewer than half of the original sample. In order to draw any reliable conclusions from studies of this type, a researcher should have at least 75-80 percent participation from the original cohort or must be able to identify the features of the people in the original cohort who were not evaluated. This study did neither. The Bearman and Bruckner (2002) study focused exclusively on opposite-sex twin pairs and reported percentages of same-sex attraction. Peter S. Bearman & Hannah Bruckner, *Opposite-Sex Twins and Adolescent Same-Sex Attraction*, 107 Am. J. Soc. 1179 (2002). Nowhere in the study do the authors mention sexual abuse as a possible factor in same-sex attraction. Similarly, the Francis (2008) study examines the hypothesized relationship of birth order and sexuality and contains no discussion of traumatic factors at all. Andrew M. Francis, *Family and Sexual Orientation: The Family-Demographic Correlates of Homosexuality in Men and Women*, J. Sex Res. 371 (2008). The author concludes more research is necessary to distinguish

potential causal factors and notes that biological theories emphasizing the role of genetics on sexual orientation show promise. *Id.* at 377.

13. The only study that purports to correlate sexual abuse and homosexuality, Roberts, Glymour, and Koenen, *Arch. Sex. Behav.* (2013) 42:16, has drawn significant criticism for its severely flawed methodology. A published comment on the study in the same journal that published the original article, for instance, points out fatal methodological flaws, concluding that the study "fail[s] to provide support for the idea that childhood maltreatment causes adult homosexuality." Drew H. Bailey & J. Michael Bailey, *Poor Instruments Lead to Poor Inferences: Comment on Roberts, Glymour, and Koenen,* Arch. Sex. Behav. (2013). In addition, the authors' treatment of parental alcohol issues, childhood poverty, presence of a stepparent and parental mental illness as interchangeable variables, is unscientific and leads to wholly unreliable results.

Sexual Orientation Change Efforts are not Part of the Established Treatment Protocols for Child Victims of Sexual Abuse

14. While homosexuality is neither a disorder nor a result of sexual abuse, there are actual psychological disorders that are clinically associated with sexual abuse, including the DSM IV disorders of Major Depressive Disorder, Somatization Disorder, Substance Abuse Disorders, Posttraumatic Stress Disorder (PTSD), Dissociative Identity Disorder, and Bulimia Nervosa.[7] Childhood sexual abuse has also been linked to

[7] Frank W. Putnam, *Ten-Year Research Update Review: Child Sexual Abuse.* 42 JOURNAL OF AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY 269, 271 (2003).

problematic behaviors that do not constitute individualized DSM IV disorders, including more sexualized behaviors than comparison groups.[8]

15. When treating children for problems associated with sexual abuse, practitioners have a duty to ensure that their clients receive the most effective and appropriate treatment available. It is therefore incumbent on responsible practitioners to select and employ mental health treatment protocols and procedures that are evidence-based and have a sound theoretical basis for use with victims of abuse.

16. There are a number of treatment protocols meeting these criteria. The National Crime Victims Research and Treatment Center and the Center for Sexual Assault and Traumatic Stress have issued guidelines (the "Treatment Guidelines") based on an effort to identify all protocols for the treatment of childhood abuse with a sound theoretical basis, substantial clinical-anecdotal literature indicating the treatment's value, no clinical or empirical evidence indicating that the treatment constitutes a substantial risk of harm to those receiving it, and empirical support for their efficacy.[9] They

[8] *Id*. at 271-272; Kathleen A. Kendall-Tackett et al., *Impact of Sexual Abuse on Children: A Review and Synthesis of Recent Empirical Studies,* 113(1) PSYCHOLOGICAL BULLETIN 164, 165-167 (1993); William N. Friedrich et al., *Child Sexual Behavior Inventory: Normative and Clinical Comparisons*, 4(3) PSYCHOLOGICAL ASSESSMENT 303, 310-311 (1992).

[9] *See* Benjamin E. Saunders, et al., *Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004),* http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf, 18-23 (Apr. 26, 2004) (describing protocol selection criteria and classification system).

concluded that 16 of the 24 protocols evaluated met those criteria.[10] Not one of the treatment protocols, however, included efforts to alter the victim's sexual orientation.

17. Even assuming that SOCE could achieve its stated goal (and the evidence overwhelmingly suggests otherwise[11]), attempting to change a person's sexual orientation is never an appropriate therapeutic response to sexual abuse. As discussed in the Treatment Guidelines, it is imperative to repair the harm to self-esteem and self-worth that sexual abuse can cause.[12] Any efforts that suggest the patient has the "wrong" sexual orientation are inimical to this goal.

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[10] *Id.* at 99-103. For example, a protocol known as Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) met the highest standards of the Treatment Guidelines. *Id.* at 102. TF-CBT "focuses on the patient's conditioned emotional associations to memories and reminders of the trauma, distorted cognitions about the event(s), and negative attributions about self and others." *Id.* at 49. TF-CBT often involves development of a "Trauma Narrative," which has been shown particularly effective in moderating fear and anxiety. *See* Esther Deblinger et al., *Trauma-Focused Cognitive Behavioral Therapy for Children: Impact of the Trauma Narrative and Treatment Length*, 28 DEPRESSION AND ANXIETY 67, 71 (2011).

[11] *See* Am. Psychol. Ass'n, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, 79 (Aug. 2009), http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf (finding "no empirical evidence that providing any type of therapy in childhood can alter adult sexual orientation"); Stewart L. Adelson & the Am. Acad. of Child and Adolesc. Psychiatry Comm. on Quality Issues, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51(9) J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 957, 968 (2012) ("There is no empirical evidence adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming.")

[12] *See* Saunders, *supra* note 14, at 25-26 ("Abuse-specific (e.g., self-blame, guilt) and abuse-related (e.g., stigmatization, shame) attributions are associated with increased distress and may lead to conditions such as depression, low self-esteem, and impaired socialization that are common in abused children.").

Sexual Orientation Change Efforts Pose a Particular Danger to Victims of Childhood Sexual Abuse

18. Although undergoing SOCE is potentially harmful to any patient, the risk appears particularly acute for victims of childhood sexual abuse. The American Psychological Association (APA) Task Force on SOCE has concluded that attempts to change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts.[13] Similarly, the American Academy of Child and Adolescent Psychiatry (AACAP) has warned that SOCE "may encourage family rejection and undermine self-esteem, connectedness and caring, important protective factors against suicidal ideation and attempts."[14] Due to this "significant risk of harm," including deaths, and the absence of "evidence that efforts to alter sexual orientation are effective, beneficial, or necessary," the AACAP has advised practitioners that SOCE is "contraindicated."[15] The Society for Adolescent Health and Medicine similarly advises that "[b]ecause reparative therapy is an unsubstantiated and harmful option, it should not be considered or recommended for teenagers who are dealing with issues surrounding their sexual orientation or gender identity…Rather, providers…[should] provide supportive counseling to promote self-acceptance and health growth."[16]

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[13] Am. Psychol. Ass'n Report, *supra* note 16, at 42.

[14] Adelson, *supra* note 16, at 968.

[15] *Id.*

[16] *Recommendations for Promoting the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Adolescents: A Position Paper of the Society for Adolescent Health and Medicine*, 52 JOURNAL OF ADOLESCENT HEALTH 506, 509 (2013).

19. Sexually abused children are particularly vulnerable. They face significantly higher risks of major depression and suicidality than non-abused children,[17] as well as altered self-perceptions including helplessness, shame, guilt, and self-blame.[18] Subjecting sexually abused minors to SOCE has no medical or scientific basis and would compound the mental health risks that this population already faces as a result of their abuse.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 12th day of September, 2013 in San Francisco, California.

MD

Laura Davies, M.D.

[16] Am. Psychol. Ass'n Report, *supra* note 16, at 42.

[17] Putnam, *supra* note 12, at 271 (reporting that "[m]ajor depression and dysthymia have been strongly associated with [childhood sexual abuse] in numerous studies," and that in one study children "reporting [childhood sexual abuse involving] intercourse had an increased odds ratio of 8.1 for major depression and 11.8 for a suicide attempt."); Kendall-Tackett, *supra* note 13, at 167 ("Depression appeared to be a particularly robust symptom across age groups and was also one that appeared frequently in adults molested as children, as two recent reviews have indicated.") (citation omitted).

[18] *See* Putnam, *supra* note 12, at 274.

EXHIBIT A

LAURA DAVIES, MD

EXPERIENCE

August 2002 – ongoing San Francisco, CA
Private Practice in Child, Adolescent, and Adult Psychiatry

- Consultative Psychiatrist at St. Luke's Hospital, California Pacific Medical Center since 2007
- Forensic work, including work with the U.S. Department of Justice, and work in criminal and immigration trials, assessing testamentary capacity, worker's compensation evaluations and malpractice consultation.
- Monitor, CA Department of Juvenile Justice, Mental Health. January-April 2011

July 2003-July 2004 UCSF-SFGH
Child Psychiatrist, Departments of Pediatrics and Psychiatry

- Supervise psychiatric and pediatric residents, psychology pre-and post- doctoral interns, medical students, and volunteers. Direct the Behavioral Assessment Clinic, addressing ADHD, PTSD, and other childhood psychiatric disorders. Provide psychotherapy and psychopharmacology services for children.

July 2003-July 2004 UCSF
Assistant Clinical Professor, Child and Adolescent Psychiatry

July 2000-June 2003, Nov. 2006-Oct. 2007
Instituto Familiar de la Raza San Francisco, CA
Staff Psychiatrist

EDUCATION

1997-2003
University of California, San Francisco
Resident, Child and Adolescent Psychiatry and General Adult Psychiatry

May 1997
University of Southern California School of Medicine
Doctor of Medicine (MD)

June 1992
Princeton University
AB *Cum laude*, Anthropology

HONORS AND AWARDS

- Irving Phillips, MD Memorial Award for Excellence in Child & Adolescent Psychiatry, June 2003
- Ginsburg Fellow, Group for the Advancement of Psychiatry 1999-2000
- AACAP Pfizer Outstanding Resident in Child and Adolescent Psychiatry Award 2000

CERTIFICATION

- American Board of Psychiatry and Neurology Diplomate since 2003, with Subspecialty Certification in Child and Adolescent Psychiatry since 2004, recertified in both in April 2013
- California Medical License since September 1998
- Qualified Medical Examiner, State of California, since 2006
- Bilingual Certification in Spanish, San Francisco Public Health Department 1998
- Calmecac Training 2001-2002 Bicultural Mental Health Training for Latinos

PRESENTATIONS

- *Adolescent Trauma: Case Presentation and Discussion* Grand Rounds Langley Porter Psychiatric Institute, Division of Child and Adolescent Psychiatry 2002
- *Sleep* San Francisco Health Plan Member Advisory Committee, August 2009
- San Francisco Chronicle, Front Page of Health Section, bimonthly

column since August 2012

PROFESSIONAL ACTIVITIES

- Member, Obama Campaign Health Care Advisory Committee, 2012 and Co-director, national Rapid Response Team, Op-Eds and Letters to the Editor
- Participant, The White House, "Improving Understanding and Engagement about the Affordable Care Act" September 28, 2012
- Expert Reviewer, Medical Board of California November 2010-August 2015
- Investigator, Child and Adolescent Psychiatry Trials Network (CAPTN), December 2006-June 2009.
- Faculty Member, REACH (Recommendations for Employing Antipsychotics in Children and Adolescents), 2004